Abstracts of Papers Presented Before a Combined Meeting of the Sections of Medicine and Obstetrics and Gynecology, December 15, 1936

1. THE SIGNIFICANCE OF PREGNANCY FOR THE TUBERCULOUS WOMAN

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During the childbearing age tuberculosis is the most fatal of all diseases in women. Young women particularly may develop small pulmonary infiltrations which cause few or no symptoms, may not give rise to abnormal physical signs, but can almost always be identified by the X-ray. Such lesions are unstable and have a tendency to break down rapidly and spread. Various factors, including pregnancy, may favor progression of the disease. Tuberculous women should be advised against becoming pregnant until the pulmonary lesions have been arrested and apparently healed under normal conditions of life for at least two years. Women who have early exudative or poorly healed lesions are in danger from the tuberculosis, and pregnancy must be considered a liability, even though the tuberculosis may not be producing obvious symptoms such as fever. In every case, complete examinations should be carried out in order to estimate the potential menace of the disease. The significance of the pregnancy can then be estimated with reasonable accuracy. Modern therapy opens the prospect of pregnancy to women who otherwise could never be advised to undertake it. The ideal is to detect the tuberculosis by proper case finding methods before the woman becomes pregnant, or at least in the first month of pregnancy. This insures better control of the situation than any other method.

2. TUBERCULOSIS FROM THE POINT OF VIEW OF THE OBSTETRICIAN

HARVEY B. MATTHEWS

Motherhood is the cherished hope of every woman. Usually during adolescence and young womanhood this desire is most manifest, and it is the age of highest incidence of Pulmonary Tuberculosis. The problem, therefore, assumes importance. Opinions, rendered by combined decisions of the tuberculosis Specialist, the expert Obstetrician, the Pediatrician, the Roentgenologist, and the Pathologist, for the individual who desires or becomes pregnant is advisable. We have no right to say "No woman with tuberculosis can safely bear children", nor can we please Mussolini and say "tuberculosis doesn't matter, let her go ahead and have children—the country needs them for soldiers".

"A middle of the road" attitude can give successful results, in a good proportion of cases, when judged by a group with a reasonable thorough understanding of the two conditions in association. Success also is dependent on the cooperation of the patient.

If tuberculous women who wish to become pregnant or who are already pregnant have "taken the cure" and have learned how to live—and have the character and determination to carry out a rigid regime —there is no good reason for them not to procreate. On the other hand, pregnancy in the active tuberculous patient, no matter how little tuberculosis is present, is dangerous—in some cases very dangerous. Therapeutic abortion, therefore, should be performed.

In the moderately advanced active cases, pregnancy is very dangerous. However, if 3 or 4 or more years are allowed to elapse following "arrest", during which time the general health has remained satisfactory, pregnancy may be undertaken with comparative safety even in these cases.

In advanced cases, especially with cavitation, it goes without argument, that pregnancy is absolutely contra-indicated.

3. THE CARDIAC FUNCTIONAL CAPACITY AS AN AID TO PROGNOSIS DURING PREGNANCY

HAROLD E. B. PARDEE

Cardiac functional capacity was discussed and its application to pregnant women outlined in detail. A series of 52 deliveries was reported from the Woman's Hospital and the Cardiac Clinic of the Polyclinic Hospital with only one death which could be attributed to an aggravation by the pregnancy. Of 28 patients with Class 1 functional capacity two developed slight cardiac symptoms during pregnancy or shortly afterwards. Of 21 patients in Class 2-a when first seen, one showed evidence of cardiac strain during and for several days after labor and died three months later, after her return home. Three became 2-b during the last trimester. One of these pregnancies was interrupted at the sixth month, the other two went to term. The other 17 patients in Class 2-a passed through pregnancy and were delivered without noteworthy tachycardia or dyspnea. Of the three patients presenting themselves in Class 2-b, two had normal deliveries, and one a cesarean. All made good recoveries. The importance of the complication of continuous auricular fibrillation was stressed. Recommendation was made that the pulse and respirations be counted every 20 minutes during labor and that a pulse over 110 with respirations over 25 should be considered a sign of approaching heart failure. It was concluded that the functional capacity rating is useful in predicting the reaction of the heart to pregnancy and labor.